FY 2007 DAP ONLY NEW/RENEWAL APPLICATION

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
HIV/AIDS DRUG ASSISTANCE PROGRAM

1. Current or Previous DAP Number (if applicable)_____

2. Name: _____ _____ _____
Last First Middle

3. Preferred Mailing Address (All DAP related information will be sent to this address):

_____

4. City: _____ State: _____ Zip Code: _____

5. County of Residence: _____ 6. Phone Number: ( ) _____

7. Social Security Number: __ __ __-__ __-__ __ __ __ 8. Date of Birth: _____
(Month/Day/Year)

9. Gender (check one):	10. Race/Ethnicity (check all that apply):	11. Are you a resident of the State of Michigan?
☐ Male ☐ Female ☐ Transgender	☐ African American ☐ Caucasian ☐ African National ☐ Hispanic/Latino ☐ Arab/Chaldean ☐ Native American ☐ Asian ☐ Pacific Islander/Native Hawaiian	☐ Yes ☐ No

12. Family Size:_____ (include yourself, and those supported by you, including spouse &/or dependants living with you)	13. Do you have Medicare? ☐ Yes ☐ No

14. My TOTAL gross (pre-tax) **monthly** income is: $_____

15. Assistance You are Requesting (check one box only): **(Page references to instructions are noted in parentheses below.)**

- ☐ Veteran's Administration co-pay assistance (pg.5)
- ☐ Private Insurance Co-pay Assistance. Private Insurance Carrier _____ (pg.6)
- ☐ County Health Plan assistance. Are you on Plan B? _____ yes _____ no (pg.9)
- ☐ Medicare Part D. Are you enrolled in a Prescription Drug Plan (PDP)/Medicare Rx Plan?_____ yes _____ no (pg.7)
  If yes, what is the name of the PDP/Medicare Rx Plan? _____
- ☐ Full drug assistance (pg. 10)

Proof of HIV Status/Lab Update (*if NEW to program must have physician signature and/or labs*)

Absolute CD4 number/mm3: _____ Test Date: __ __/__ __/__ __ __ __ HIV RNA/ Viral Load: _____ copies Test Date: __ __/__ __/__ __ __ __ Physician Name _____ Physician Signature _____ Prescriber DEA #: _____ __ __/__ __/__ __ __ __	Labs attached? ☐ Yes ☐ No ***(Labs must show a detectable viral load and/or Positive/Reactive Western Blot.)** **(See pg. 12 in the instructions.)**

AUTHORIZATION FOR RELEASE OF INFORMATION

I understand that if I become enrolled in a health insurance program that pays (100%) for my medication or I qualify for medical assistance through other federal, state or county medical benefit programs, I must immediately notify the Michigan Department of Community Health, Drug Assistance Program and my pharmacist, and that I also am not eligible for DAP assistance. I understand that as a Medicare recipient I must enroll in PDP or provide proof of creditable coverage to the DAP.

I authorize the Michigan Department of Community Health, Drug Assistance Program to receive, disclose, and discuss medical/dental information related to the care and treatment of my HIV infection with any health insurance or government health insurance program representative, or other individuals as required and necessary. In addition, specific agencies/representatives and phone numbers are listed below.

The information that I have provided on this application is complete and true to the best of my knowledge, and I certify that I meet the eligibility requirements as specified in the instructions that are required for me to be on the Drug Assistance Program.

I understand that if any of the information provided on this application changes that I will notify the DAP immediately. In addition, I understand that failure to report changes and/or reporting of inaccurate information will affect DAP coverage and program eligibility.

This application, when completed, contains patient information that must be protected in accordance with the Health Insurance Portability and Accountability Act.

AGENCY OR PERSON **PHONE NUMBER**

_____

Case Management (please list name and/or agency and phone number if you have one)

_____

Physician

_____

Other (family members, friends, partners)

_____ _____ **This consent expires 3/31/2008**

Signature of Applicant/Parent/Guardian **Date**

PLEASE MAIL OR FAX APPLICATION AND ANY SUPPORTING DOCUMENTATION TO:
Drug Assistance Program
109 Michigan Avenue, 9th Floor
Lansing, Michigan 48913
Phone: (888) 826-6565
Fax (517) 335-7723

DAP office use only		
WV Code _____	**Confirmed DAP Coverage:**	
	☐ County Program, Plan B(2000) – Co# _____ ☐ Full Coverage (3000)	Denied:
	☐ Private Insurance (4000) ☐ Emergency (5000) 14-Days Only	Date _ _/ _ _ /_ _ _ _
	☐ Spendown (6000) ☐ Medicare (7000)	Reason Code: _____
	Approved _____ Date _ _/ _ _ / _ _ _ _ Intials ___ ___-- ___ ___ ___ --___ ___ ___ FY/JD/D#	Initials_____